

PATIENT HISTORY

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Date \_\_\_\_\_

Would you like more information on any of the following? Refractive Surgery Contact Lenses Cataracts Dry Eye
Diabetic Eye Disease Eyelid Surgery Glaucoma Botox

EYE HISTORY

- 1. Are you currently experiencing any eye symptoms? Eye Pain Blurred Vision Eyelid Crusting Discharge
Floaters Light Sensitivity Double Vision Light Flashes
2. Do you wear glasses?
3. Do you wear contacts?
4. Do you have problems reading?
5. Have you ever had an eye injury or eye surgery?
6. Have you ever had any eye disease?
7. Do you take any eye medications?

MEDICAL HISTORY

- 1. Do you have any medical conditions? e.g. diabetes, cholesterol, high blood pressure, arthritis, thyroid disorder, gerd
2. Have you ever had any surgery?
3. Have you ever been hospitalized for any reason other than surgery?
4. List your prescription and over-the-counter medications:
5. Do you have any drug or food allergies?

REVIEW OF SYSTEMS

Table with 2 columns: Problem description, Yes/No checkboxes. Rows include Chronic fever, Ear/nose/throat problems, Heart problems, Respiratory problems, Gastrointestinal problems, Urinary problems, Skin problems, Musculoskeletal problems, Neurologic problems, Psychiatric problems.

FAMILY AND SOCIAL HISTORY

- 1. Do any medical or eye diseases run in your family?
2. Do you smoke?
3. Do you drink alcohol?
4. If employed, how many hours per week do you work?

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_ Tech init \_\_\_\_\_

Updated on \_\_\_\_\_ by \_\_\_\_\_ changes?
Reviewed by \_\_\_\_\_, MD